

Louisiana's Medicaid Program

Pre-Application Clearance

Name:	Today's Date:
Please answer the following questions about yourself and all persons who live with you.	
1. Is anyone blind?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Is anyone age 65 or older?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Is anyone disabled or incapacitated?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Is anyone pregnant?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Is anyone under age 19?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Is anyone eligible for Medicare Part A (Hospital) Insurance?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Is anyone eligible for Medicare Part B (Physician Services) Insurance?	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Is anyone a resident of or planning to enter a nursing facility, medical institution or Waiver program?	<input type="checkbox"/> Yes <input type="checkbox"/> No
A) If you have answered YES to any question, you may be eligible for Medicaid. If you wish to pursue a Medicaid application for anyone who is not under age 19, please check (✓) this block (☐), provide the information below and sign this form. B) If you have answered YES only to question 5, you are entitled to complete a simplified application form for LaCHIP, which provides Medicaid only to persons under age 19. If you wish to pursue a LaCHIP application, please check (✓) this block (☐), complete the information below and sign this form. C) If you wish to apply for FITAP cash or Refugee assistance, you must contact your local Office of Family Support. If you wish to apply for SSI cash benefits, you must contact the Social Security office nearest to your home.	
Mailing Address: _____ _____	Parish:
Signature:	Telephone #: ()